

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011609

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 740

300
1-57

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) Clayton		c. CITY OR TOWN Webster Groves	
c. FULL NAME OF HOSPITAL OR INSTITUTION County Hosp.		d. STREET ADDRESS 369 So. Maple	
3. NAME OF DECEASED (Type or print) James Nicholas Kariores		4. DATE OF DEATH Month March Day 18 Year 1959	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1889
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restuarant		11. BIRTHPLACE (City and state or country) Patros, Greece	
13a. FATHER'S NAME Unknown		14. NAME OF HUSBAND OR WIFE Eunice Kariores	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 498-34-8272	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas with Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) jaundice DUE TO (c) 157X		INTERVAL BETWEEN ONSET AND DEATH 2/27/59. 3/18/59	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Uremia due to polycystic kidneys		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION Clayton Mo.	
21. I attended the deceased from 2-27-59 to 3-18-59 and last saw him alive on 3-18-59 Death occurred at 12:45 P. m on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Angelo A. Spens M.D.	
22b. ADDRESS 6015 Brentwood, Clayton Mo.		22c. DATE SIGNED 3/18/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 3-21-59	23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cem.	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Parker-Aldrich		25. DATE RECD. BY LOCAL REG. 3-19-59	
ADDRESS Webster Groves		26. REGISTRAR'S SIGNATURE John C. Murphy M.D.	

(Licensed Embolmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Leslie Welch*

Licensed Embalmer No. *4395*

P. O. Address *Water Green*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.